

# MENTAL HEALTH AND DISABILITY SERVICES COMMISSION

August 21, 2014, 9:30 am to 3:00 pm

Polk County River Place, Room 1

2309 Euclid Avenue, Des Moines, IA

## MEETING MINUTES

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### MHDS COMMISSION MEMBERS PRESENT:

Thomas Bouska  
Neil Broderick  
Thomas Broeker  
Jill Davisson  
Marsha Edgington  
Lynn Grobe  
Kathryn Johnson  
Betty King

Geoffrey Lauer  
Brett McLain  
Rebecca Peterson  
Michael Polich  
Deb Schildroth  
Patrick Schmitz  
Suzanne Watson

### MHDS COMMISSION MEMBERS ABSENT:

Richard Crouch  
Senator Joni Ernst  
Senator Jack Hatch  
Representative Dave Heaton

Representative Lisa Heddens  
Sharon Lambert  
Marilyn Seemann

### OTHER ATTENDEES:

Theresa Armstrong	MHDS, Bureau Chief Community Services & Planning
Bob Bacon	U of Iowa Center for Disabilities and Development
Jess Benson	Legislative Services Agency
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI Greater DM
Kyle Carlson	Magellan Health Services of Iowa
Eileen Creager	Aging Resources of Central Iowa
Diane Diamond	DHS, Targeted Case Management
Kristi Dierking	Marion County
Connie Fanselow	MHDS, Community Services & Planning/CDD
Jim Friberg	Department of Inspections and Appeals
June Klein	Brain Injury Alliance of Iowa/Olmstead Consumer Taskforce
David Klinkenborg	IHH Program Associate Director, Magellan Health Services
Liz O'Hara	U of Iowa Center for Disabilities and Development
Brooke Lovelace	MFP Coordinator, U of Iowa Center for Disabilities and Development/Iowa Medicaid Enterprise
Kelley Pennington	IHH Program Director, Magellan Health Services
John Pollak	Legislative Services Agency
Molly Steffen	Iowa State Association of Counties

## WELCOME AND CALL TO ORDER

Patrick Schmitz called the meeting to order at 9:35 a.m. and led introductions. Quorum was established with fourteen members present. No conflicts of interest were identified for this meeting.

## APPROVAL OF MINUTES

A motion was made by Lynn Grobe to approve the minutes of the July 17, 2014 meeting as presented. Geoff Lauer seconded the motion. The motion passed unanimously.

## COST INCREASE RECOMMENDATION LETTER

Patrick Schmitz led a discussion of the draft cost increase letter developed by committee. The letter is to be sent on behalf of the Commission to Director Palmer to provide input to the development of the Department's budget estimate for SFY 16 regarding the increase in costs of providing services, as well as the budget for disability services in general. The Commission members reviewed the draft and Patrick read the two-part draft recommendation of the committee:

- First, we recommend increasing the prior year's budget to address inflation, overall population growth based on the most recent census data, and growth in service utilization. Based on cost increase and inflation factors for mental health services published by the Substance Abuse and Mental Health Services Administration (SAMHSA), we propose applying an inflation and growth factor of at least two percent.
- Second, we recommend increases in funding that support the full implementation of core services and provide opportunities for all regions to begin offering additional ("core plus") services throughout the system, including expanded early intervention services and prevention services designed to reduce the need for longer term, more intensive, and more costly services.

Discussion - Geoff Lauer suggested requesting additional dollars to reduce or eliminate the Medicaid HCBS Waiver waiting lists for the benefit of people who are at risk of institutionalization. Tom Bouska agreed and said that requesting additional dollars to reduce the lists might be more likely to succeed than requesting funds to clear the list entirely.

Motion – Geoff Lauer made a motion to approve the letter with the addition of language in support of additional funding to address HCBS Waiver waiting lists. Tom Broeker seconded the motion.

Suzanne Watson joined the meeting.

Discussion – Deb Schildroth suggested also adding a point to address the Medicaid offset and requesting allocation of additional funds as needed for stabilization. She noted that there is concern about core plus services being underfunded if the Medicaid offset continues.

Geoff Lauer withdrew his previous motion.

Motion & Vote - Tom Bouska made a motion to approve the letter with the addition of language in support of additional funding to address HCBS Waiver waiting lists and additional language recommending that funds from the Medicaid offset be designated to stabilize the resources available to the MHDS regions for the full implementation of core services and development of core plus services. Jill Davisson seconded the motion. The motion passed unanimously.

## DHS/MHDS REPORT

Theresa Armstrong presented an update on DHS and MHDS activities:

Regions – Regional policies and procedures are due October 1. Regional Annual Service and Budget Plans have been received and all, except Marion and Mahaska, which have been provisionally approved to operate as a two county region, have been approved. That plan is expected to be approved soon. It has been delayed a little because of the time involved with the provisional approval process.

Annual Service and Budget Plan Overview:

- About 46% of funds are budgeted to core services
- About 6% of funds are budgeted to additional (core plus) services:
  - 11 regions have included community and facility based crisis response services (13 of the regions are looking at either developing or funding some crisis services)
  - 7 regions have included justice involved services
  - 9 regions have included additional Evidence Based Practice (EBP) services (such as supported employment and supported housing)
- About 8 % of funds are budgeted to administration
- The remaining funds are budgeted to other services, including educational, information and referral, housing and rental assistance, and transportation

The budgets for all the regions total \$146 million. The regions report \$183 million in revenues available, which includes the fund balances they need to carryover for cash flow purposes.

The plans include some services to non-mandated populations:

- 2 regions will cover some services for children
- 15 regions include some services for persons with developmental disabilities (other than intellectual disabilities)
- 7 regions include some services for persons with brain injury

Theresa said a summary of the plans is being developed and will be shared when it is complete. The Regional Annual Service and Budget Plans are posted on the DHS website at: <http://dhs.iowa.gov/mhds-providers/providers-regions/regions/service-budget>

In response to a question, Theresa clarified that the new crisis response services cover both adults and children. She was also asked there is any kind of list of what cannot be funded. Theresa responded that there are exclusions that apply to who can be eligible for services, but regions have flexibility in determining what specific types of services they will fund beyond core services. She noted, for example that some regions are continuing to fund sheltered work and residential care facilities (RCFs) and some are not. Some are also looking at transitioning those services to more integrated types of services over time because they have responsibilities to follow Olmstead principles and federal community living requirements.

Iowa Health and Wellness Plan (IHAWP) – As of August 10, there were 110,153 people enrolled, which is down a little from last month. That may be because the re-enrollment of the IowaCare population is ongoing. Last year they were automatically enrolled, so the process of re-enrollment may cause some fluctuation in enrollment numbers until the re-enrollments are processed. The number of people identified as medically exempt has increased to 11,448. That identification process takes some additional time after enrollment.

Medicaid Offset Administrative Rules – The Medicaid Offset rules have been published in the new Iowa Administrative Bulletin and public comment will be accepted until September 9. These rules will be filed “emergency after notice” because of the short timeline for implementation, which means they will take effect after the public notice and comment period. The rules state that the data is to be submitted by September 19, although the soonest the rules can complete the approval process is September 25. The Department will be asking the Commission to schedule a special telephone meeting on September 25 to consider their approval so they can become effective on that date.

Crisis Response Administrative Rules – The rules for accreditation of crisis response services under a new division of Chapter 24 have been publicly noticed and about 170 comments have been received. The Department is working on reviewing and responding to the comment. There will be some changes made to the rules in response to the comments. The Department expects to bring the rules back to the Commission at the next meeting to consider adoption.

Subacute Administrative Rules – The subacute rules have been developed by the Department of Inspections and Appeals. The rules have been submitted to Legislative Services Agency (LSA) and will be published in the Iowa Administrative Bulletin on September 3. Jim Friberg noted that there will be a public hearing on the rules at 10:00 am on September 23 in the Lucas Building.

Non-Emergency Medical Transportation - Currently Medicaid has a transportation broker, which is a company that manages the NEMT service for Medicaid. IME has put out a public request for information to gather feedback from users, providers, and others on how the service has been working. A new RFP (Request for Proposals) was put out August 1 and a new contract for the service will start July 1, 2015.

Key areas of concern about the service include:

- Capitation rate - Medicaid has paid a flat rate to the broker. IME felt that keeping a capped rate is important, but will conduct oversight and monitoring differently and use incentive payments and payment withholding to assure better quality oversight of the broker.
- Oversight of the broker - IME will automatically withhold 10% of monthly payments. The broker must meet certain outcomes to receive the 10%. The outcomes center around:
  - Call center performance
  - Service performance
  - Reimbursement to providers
  - Education and training of members and providers

The new contract will require that the broker:

- meets timelines for reporting data to the Department
- hires a quality assurance advocate to assist members
- provides education to providers and members

A customer service score card will be made available to the public that includes information on complaints, formal complaints to the department, appeals that the Department reversed, and call center performance measures. HCBS services transportation may be added later as a pilot. The RFP is posted online and available for review.

Kathy Johnson commented that integrated health home staff find they need to transport people frequently because there is no other transportation available.

Balancing Incentives Program (BIP) – Iowa applied for the BIP program in 2012 (formerly the Balancing Incentives Payment Program or BIPP). It is a federal award that calls for moving more dollars toward community-based programs. Iowa started with about 42% of spending going to community-based services, and as of March of this year, 52% of spending is for community-based programs. The goal is to keep the percentage above 50%, although there may be some fluctuation. Iowa receives 2% more in FMAP (Federal Medical Assistance Percentage), which is the federal Medicaid match amount, for the home and community based services.

The BIP program requires that states implement three practices:

- No wrong door access - DHS has worked collaboratively with the Iowa Department on Aging and their ADRCs (Aging and Disability Resource Centers) to achieve no wrong door access. The AAAs (Area Agencies on Aging) and regions will serve as physical locations for access points. There is a statewide telephone number (Life Long Links) people can call to be connected with what they need, and information is available online. Life Long Links and COMPASS are working together at combining information resources into a web-based system.

- Core standardized assessments - Standardized assessments are starting to be done. Iowa is starting with the SIS (Supports Intensity Scale) for people with intellectual disabilities. A contract has been awarded to Telligen to conduct the SIS assessments, which began this month. Assessments tools for other disability groups will be identified and rolled out over the next year.
- Conflict-free case management - Conflict-free case management is about preventing conflicts of interest and ensuring that individuals have freedom of choice in selecting service providers and agencies.

Kathy Johnson asked if an assessment has been identified for persons with SMI (Serious Mental Illness) Theresa responded that it is not included in the Telligen contract. MHPS and IME will probably be working together to make that determination. Some of the assessments that have been suggested, such as the LOCUS for people with SMI and the Mayo Portland for people with brain injury, do not quite meet all the BIP requirements, so work is still being done on that.

Theresa noted that there is a program in San Antonio, Texas that has gotten some attention on NPR (National Public Radio) and there is some interest in looking at a similar model here in Iowa. It involves training law enforcement officers to handle people with serious mental illness differently and work to divert them from jail into treatment. The NPR story is available online at:

<http://www.npr.org/blogs/health/2014/08/19/338895262/mental-health-cops-help-reweave-social-safety-net-in-san-antonio?sc=tw>

## STATE RESOURCE CENTERS BARRIER REPORT 2013

Marsha Edgington presented an overview of the Glenwood and Woodward Resource Centers Annual Report of Barriers to Integration. The purpose of the report is to provide a comprehensive assessment of the major barriers to individuals moving to more integrated settings and indicate actions the State can take to overcome the barriers. The report came about as a part of a Department of Justice settlement with the Resource Centers in 2004. This report is for the 2013 calendar year.

On December 31, 2013, there were 251 adults and 6 children under the age of 18 residing at Glenwood SRC, and 164 adults and 4 children or adolescents under the age of 18 residing at Woodward SRC. Currently there are 246 adults and 4 children living at the Glenwood facility and 156 adults and 4 children or adolescents living at the Woodward facility. The SRCs have a goal of moving people into community settings with a net decrease in their residential population of 12 each year. The target population numbers for 2014 are 231 for Glenwood and 146 for Woodward.

There is one waiting list for both SRCs and which one a person goes to depends on where there are openings, what the best fit for the person is, and the geographic preference of the person and their guardian. As of August 19, there were seven people on the waiting list.

Five major barriers have been identified:

1. Interfering behavior that makes it difficult to ensure safety for the individual or others. These types of behaviors include aggression, self-injury, unhealthy obsessions, water intoxication, sexual offending, fire setting, and elopement.
  - This was a barrier for 83% of adults
  - This was a barrier for 80% of children and adolescents under the age of 18
  - The numbers increase with aging and dementia
2. Underdeveloped social skills, which includes extreme screaming, verbal threats, repeated unfounded accusations against staff, inappropriate touch, and other disruptive behaviors.
  - This was a barrier for 25% of adults
  - This was a barrier for 60% of children and adolescents under the age of 18
3. Health and safety, which includes multiple severe or sensitive health conditions that require a high level of care and monitoring.
  - This was a barrier for 30% of adults
  - This was a barrier for 10% of children and adolescents under the age of 18
4. Day programming or vocational opportunities, which include the availability of education, employment, or other daytime activities that provide the person with meaning, interest, and structure. Paid work is not consistently available, and work opportunities may be too simple or repetitive to be interesting. Support may not be sufficient for persons who need a higher level of job coaching because of interfering behaviors.
  - This was a barrier for 9% of adults
  - This was a barrier for 10% of children and adolescents under the age of 18
5. Individual, family, or guardian reluctance to leaving the SRC. This happens for a variety of reasons, including concerns about the level of support in the community, concerns about a lack of a safety net if problems arise, individuals who have lived at the SRC for many years, some since they were small children, and consider it to be their home, and individuals who have a lot of difficulty adjusting to change.
  - This was a barrier for 68% of adults
  - This was a barrier for 10% of children and adolescents under the age of 18
  - For Glenwood, the numbers were 77% of adults and 17% of youth
  - For Woodward, the number were 52% of adults and 0% of youth

During the last fiscal year, Woodward moved 26 people out to other settings and admitted 11 people. Generally, the people coming to the SRCs have a higher number of interfering behaviors than the people who are moving out. It is difficult to be admitted and those who are have a very high level of need.

Betty King asked if there are people that the SRCs cannot serve who go out of state or to another type of setting. Marsha responded that there is no one the SRCs cannot serve, but a person may be placed elsewhere through court action.

#### Trends:

- The percentage of people experiencing the interfering behavior barrier has increased from 59% of adults in 2012 to 83% of adults in 2013.
- The percentage of people experiencing the underdeveloped social skills barrier has decreased from 35% of adults in 2012 to 25% of adults in 2013.
- The percentage of people experiencing the significant medical needs barrier has remained at 30% since 2011.
- The percentage of people experiencing the day programming/vocation barrier has continued to be under-reported at 9% of adults.
- The percentage of people experiencing family or guardian reluctance has increased from 61% of adults in 2012 to 68% in 2013. That trend reflects more reluctance on the part of some who have recently been admitted.

Marsha clarified that everyone who is being served in the SRCs could be served in the community with the right level of supports.

#### Overall Actions Taken to Address Barriers:

- The SRC superintendents have been active participants in Iowa's MHDS system redesign efforts to improve access to services and supports in the community
- Both SRCs continue to request permission from guardians and refer residents to Money Follows the Person to work with a transition specialist
- Woodward SRC has started estimating the length of stay at the time of admission and making a plan to build skills for moving back to the community

#### Actions Taken to Address the Interfering Behavior Barrier:

- Individual and group therapy and counseling support are provided at the SRCs and the SRCs work with community providers
- Glenwood SRC continues to use a trauma screening tool to ensure that all mental health needs are addressed
- Dialectical Behavior Therapy (DBT) is provided as a structure for individual counseling and also in skills groups
- Woodward SRC provides DBT training for new staff and refresher training for all staff
- Consultation and training is offered to community providers to expand their skills to support people moving out of the SRCs; this includes the I-TABS program (Iowa Technical Assistance and Behavior Support), led by Susan Smith, a Board Certified Behavior Analyst
- Residential and vocational agencies receive training as a part of an individual's transition process; community staff shadows SRC staff before discharge and SRC staff assists community staff after the move; training is provided to direct support staff and supervisors during the transition period
- The Woodward SRC Autism Resource Team provides training to community providers and pharmacy interns



- The APPLE (Adaptive Prosocial Performance Learning Environment) program at Woodward SRC provides services to address sexual offending behaviors and sex offender services groups are held weekly
- The APPLE team provides consultation and training to community providers

Actions Taken to Address the Individual or Family Reluctance Barrier:

- Woodward SRC sends information to guardians and family members about the MFP program and community providers in the person's preferred area of the state; staff and family are involved in visiting and touring provider homes
- People are encouraged to share their preferences and talk to local providers and Central Point of Coordination (CPC) administrators (now regions)
- Success stories about people who have moved out into the community are shared with families
- Providers are encouraged to expand or develop new services in areas identified as needed
- Interdisciplinary teams work to obtain specific information from individuals and guardians about the reasons for their reluctance
- Both SRCs work with MFP in a statewide stakeholder's workgroup
- Woodward SRC participates in Polk County Health Services and Story County provider meetings to share information about persons interested in moving to those areas
- Social workers continue to learn about services and supports available in communities throughout the state and share that information with individuals and families

Actions Taken to Address the Health Supports Barrier:

- SRCs are working to increase their knowledge of community providers' ability to provide health supports
- SRCs are increasing awareness of providers who offer accessible housing and transportation through provider visits

Actions Taken to Address the Day Programming/Vocational Supports Barrier:

- SRCs work with the MFP vocational specialist
- Community providers have been invited to tour the SRCs to see how vocational services are provided
- Community providers have been invited to tour Glenwood SRC's LIFE Center, which is a day programming site

Census Reduction: The census of both SRCs is reducing. They are committed to continuing to help people move to the communities they choose and stay there with the supports they need. Actions taken to support continued census reduction include:

- Educating others to shift their thinking of the SRCs from a long term residential setting to a short term treatment resource
- Using an admission inquiry process that focuses on preventing the need for admission

- Focusing on the specific reasons that community providers are unable to support the person and developing programming and supports to address those reasons
- Changing practices at the SRCs so they are more similar to what people will experience living in the community

Transition – The SRCs are placing an emphasis on securing appropriate services and supports before the individual moves so that the experience will be successful, including:

- Completing comprehensive functional assessments to identify essential support for health and safety
- Written transition plans are developed by the person's Interdisciplinary Team (IDT), which includes the individual and their family
- Providing training to community provider staff
- Providing follow-up by SRC staff after the move
- Including the case manager throughout the planning and moving process and transferring oversight to the case manager after discharge

Marsha said that both facilities are becoming more proficient at working with community providers and delivering the training they need. No one who has moved out of Woodward into the community has returned during the last year.

Suzanne Watson asked if there is any information about how many people want to be on the waiting list. Marsha responded that during SFY (State Fiscal Year) 2014, there were 41 formal applications, 15 of those were approved for the waiting list, and 7 are still pending. About 44% of applications are approved for the waiting list. In recent years, the number of applications received has varied from 29 to 52 in a given year. Marsha said there is a very rigorous process to ensure that all other options have been pursued before a person is admitted to one of the SRCs.

Suzanne asked if the SRCs have information about what happens to those who have applied but are not approved to be admitted. Marsha responded that she did not have that information. The SRCs do follow those who are on the waiting list. Currently there are no youth under age 18 on the list, 2 individuals between age 18 and 21, and 7 individuals over age 21.

Mike Polich asked what happens if a transition does not work out and the person wanted to be re-admitted. Marsha responded that if the person was not in a "return agreement status," which is usually within 30, 60, or 90 days of discharge, the person would have to go back through the application process again and might be placed on a waiting list.

Suzanne Watson expressed concern that a person may do something and end up in jail because neither the SRC nor the community provider can take them back. Marsha agreed that is a concern and it could happen. Marsha noted that rigorous admission standards are part of the plan to continue a minimum reduction of 12 beds annually at each SRC. Suzanne also asked if people can still be admitted for a time limited assessment. Marsha responded that time limited assessment admissions have been used to circumvent the regular admission process and get people in a "back door," so

the SRCs are very cautious about that. They are very willing to help a committed, but struggling provider to fill a gap while they hire or train new staff and put additional supports in place.

Neil Broderick asked if there is also a plan to reduce staff with the reduction in census. Marsha responded that staff is being reduced. There was a reduction in force a few years ago and now reductions continue through attrition. When a staff vacancy occurs, the SRCs look closely at whether the vacancy should be filled. The SRCs have also consolidated the use of their physical plants and fewer homes are occupied as the census drops.

## MONEY FOLLOWS THE PERSON UPDATE

Brooke Lovelace, MFP Coordinator, presented an update on the Money Follows the Person program and shared a handout outlining MFP statistics.

Overview: Money Follows the Person is a federal award that was offered to states in 2007 to transition people from facility-based living to community-based living. The program offers enhanced services and supports for the transition first year. Iowa started by working to move individuals with an intellectual disability (ID) or brain injury (BI) diagnosis out of the State Resource Centers and other ICFs/ID (Intermediate Care Facilities for persons with Intellectual Disabilities). In January of 2014, Iowa received permission from CMS (Centers for Medicare and Medicaid Services) to also work with people living in nursing facilities who have ID or BI to transition to community living.

Each person works with a transition specialist while they are still living in the facility and a plan is developed for the move. The transition specialist assists in preparing for and making the move, and continues to work with the person for the first year following the move. They help to set up the person's new house or apartment with furniture, supplies, utility deposits, grocery staples, and clothing that are needed. MFP funds can pay for enhanced environmental modifications to the home, assistive technology, or durable medical equipment costs that are beyond what Medicaid coverage allows. MFP can also fund mental health outreach, behavioral programming, and crisis services in addition to the services included in the HCBS (Home and Community Based Services) Waiver.

MFP funds can be used to reimburse facility and community providers for training time and costs. MFP has a full time behavioral specialist, Stacy Lane O'Brien, on staff. Stacy is a Board Certified Behavior Analyst. She meets with the person while they are still living in the facility to develop a behavior plan and trains the community staff on how to implement the plan. She also provides ongoing consultation, and positive behavior support training. Her expertise is paid for with 100% federal funds. MFP also has an employment specialist, Sue Ann Morrow, who works with people while they are still in the facility and starts the process to refer them to vocational rehabilitation services. Her position is also 100% federally funded. After one year in the community, MFP support ends and individuals receive services through the HCBS ID or BI Waiver. MFP clients can also access HCBS Waiver services during the first year while they are also receiving enhanced supports through MFP.

#### MFP Numbers:

- 604 individuals have been referred to MFP since September 2008
- 329 individuals have transitioned out of ICFs/ID or nursing facilities since September 2008
  - 9 in calendar year 2008
  - 53 in calendar year 2009
  - 56 in calendar year 2010
  - 55 in calendar year 2011
  - 49 in calendar year 2012
  - 51 in calendar year 2013
  - 56 in calendar year 2014
- 8 individuals have moved back to Iowa from out of state placements
- 193 individuals were currently active in the MFP program on July 31, 2014 (this includes those who have moved into the community within the last 365 days and those that are in the transition planning phase)
- 212 individuals have successfully complete 365 days of MFP services and have transitioned to the Intellectual Disabilities Waiver
- 29 individuals have returned to an ICF/ID after transition (about 8%)
- 9 of the individuals who returned to an ICF/ID or nursing facility transitioned back into the community

Iowa's annual goal has been 56. 2014 is the first year that goal will be exceeded. It is anticipated that 10 to 15 more people will transition to community living by the end of the year. Of the 56 that have moved so far this year, 43 were living in ICFs/ID and 13 were living in nursing facilities. MFP staff continue to engage in outreach and education to family members and attend annual interdisciplinary meetings at the SRCs to ensure that people have the information they need about MFP and other options.

#### Sources of Referrals to MFP:

- 136 from Woodward State Resource Center
- 78 from Glenwood State Resource Center
- 197 from other ICF/ID providers
- 13 from nursing facilities
- 11 from out of state ICFs/ID
- 10 from out of state HCBS providers
- 34 family members and guardians
- 48 from counties
- 51 from Targeted Case Managers
- 6 from ADRC Options Counselors
- 8 from the individual
- 12 from a community HCBS provider

Brooke noted that the numbers don't exactly match because some people move from SRCs to smaller facilities. In addition, Transition Specialists have attended 790 annual ICF/ID meetings since 2013, and 186 providers have enrolled to provide MFP services, including mental health outreach, nurse delegation, behavioral programming, and crisis intervention services.

#### Day activities:

- 22% of current MFP clients are using pre-vocational services
- 9% of current MFP clients are in school
- 28% of current MFP clients are using day habilitation services
- 28% of current MFP clients are not in an employment of day activity service
- 8% of current MFP clients are using supported employment or IVRS services
- 0% of current MFP clients are competitively employed
- 1% of current MFP clients are using supported employment with a job coach
- 3% of current MFP clients are using adult day services
- 1% of current MFP clients are using enclave services
- 0% of current MFP clients are using county funded sheltered workshop services
- 0% of current MFP clients are volunteering in the community

Costs: The average cost per person for all qualified waiver series, permanent services added to the waiver, demonstration services, and supplemental services during the 1 year MFP period is \$102,147. The FMAP (percentage of Medicaid costs paid by the federal government) for the first year is 80.9%. The state is required by CMS to spend the difference between the regular FMAP rate received for Medicaid services and the enhanced rate on things that will help to rebalance the system toward community-based services. CMS refers to it as the Rebalancing Fund. Rebalancing funds have supported activities such as I-TABS, a portion of the information and referral services available through COMPASS, and the Supports Intensity Scale pilot project that was completed about two years ago,

Marsha Edgington asked if the number of returns is declining. Brooke responded that the number of people returning to facilities has stayed fairly steady at 1 to 2 per year. They usually return because community providers do not have the staff capacity to serve them. Brooke noted that one of the biggest challenges is finding providers with the right skill set and the ability to offer appropriate programming. That is an important part of the role of the MFP Behavior Specialist.

#### Challenges:

- Finding employment or meaningful daytime activities and supported employment providers
- Recruiting providers in rural or smaller communities where individuals want to live
- Providers can be quick to discharge when problems arise and behavioral plans are not always followed
- Providers can try to move too quickly in transitioning the individual before careful planning and take place
- Emergency situations arise where an ICF/ID provider has given an individual a 30-day discharge notice at the same time the person is referred to MFP
- There has been some reluctance from ICF/ID providers to assist with transition planning
- The HCBS Rent Subsidy program is not always available
- Providers continue to experience high staff turnover rates
- There is a need for crisis intervention services

- Guardians can refuse to sign an informed consent agreement to begin transition planning
- There are delays in changing the payee from the ICF/ID to a new provider, which limits access to SSI benefits for rent and monthly expenses

#### Opportunities:

- Since January 2014, individuals with ID or BI living in nursing facilities are eligible for MFP
- Since January 2014, individuals only need to live in a facility for 90 days to be eligible for MFP (previously it was 6 months)
- The MFP Behavior Specialist can provide Positive Behavioral Supports Training, and other training and consultation to MFP providers
- The MFP Employment Specialist can work with individuals and others to increase employment opportunities and address employment barriers
- Since 2013, Transition Specialists have been attending annual ICF/ID Interdisciplinary Team meetings
- Providers and others have opportunities for additional training through I-TABS
- Providers continue to have free access to the College of Direct Support (CDS) web-based trainings
- Progress has been made in the development of integrated systems of care to address complex and multi-occurring issues
- Providers can request individual consultation with IME staff to address barriers that impact their ability to serve people transitioning into the community

An RFP (Request for Proposals) is expected to be released for providers who want to close ICFs/ID and become HCBS Waiver providers.

Suzanne Watson commented that there is a need for agencies that can provide the appropriate level of services. There is some concern that providers may agree to take people without having the capacity to adequately provide for their needs.

Bob Bacon pointed out that the Department has contracted with CDD to operate the MFP program since it started in 2008. He said it was significant that the SRC Barriers Report was presented first. The same barriers have been identified year after year, which indicates some things need to be done differently and changes to infrastructure need to be made so that providers have more access to crisis services that serve people with intellectual disabilities as well as people with mental health needs. Bob said he has been involved in discussions with psychiatrists at the University of Iowa who have experience with ACT (Assertive Community Treatment) for people with mental illness and are interested in forming ACT-type teams for people with ID. Having that resource in each MHDS region would enhance the capacity of providers. They would be more willing to serve people with challenging behaviors if they know they have access to crisis supports and training for prevention. There is interest in finding opportunities to fund an interdisciplinary crisis team and training team to build statewide capacity.

Brooke said that MFP is anticipated to be available through 2018 or 2019. She shared an MFP “List of Firsts.” When people complete their first year of community living, they are asked to come up with a list of “firsts” that they experienced since moving into the community. Some of the examples include:

- Cooking dinner for my mom
- Staying overnight in a hotel
- Having my first “alone” time in seven years
- Going to an I-Cubs game
- Opening my first bank account
- Have a pet duck and chickens that lay eggs
- Grilling out
- Seeing Grandma for Thanksgiving for the first time since I was a little girl, and seeing my sister for Christmas
- Trying a zip line
- Having my own mailbox
- Joining a baseball league
- Going to prom without staff
- Getting my first pay check from Pizza Ranch
- Attending Cyclone Football Games and tailgating with my family

A break for lunch was taken at 12:15 p.m.

The meeting resumed at 1:20 p.m.

#### UPDATE ON INTEGRATED HEALTH HOME (IHH) IMPLEMENTATION

Kelley Pennington, Director of the IHH program at Magellan Health Services, and David Klinkenborg, an Associate Director of the IHH program, presented an update on the Integrated Health Home Initiative.

Overview: The IHH initiative in Iowa is a developing process that started as an opportunity through the ACA (Affordable Care Act). Magellan Health Services is partnering with IME to implement the program. It involves moving to a “whole person” model of addressing mental health needs. The federal government pays 90% of the Medicaid costs for the first two years for each of the phase-in groups.

IME rolled out a health home program for individuals with two or more chronic health conditions a year ahead of the IHH program. A person with a serious mental illness (SMI) would qualify as a person with a chronic health condition. Magellan’s IHH program follows the same principles as the medical health home, but is focused in the population of people with SMI and on children with SED (Serious Emotional Disorders). Children will usually qualify if they have any mental health related diagnosis and a functional impairment.

There evidence that persons with SMI often have co-occurring health conditions that are addressed poorly, if at all. One often-quoted study found that people with SMI die, on the average, 25 years sooner than people without SMI, and that is often due to

untreated physical health conditions. IHH focuses on the whole person and making sure they have access to primary care, care coordination, and any specialty care they need. There is also attention to quality of life factors such as housing, transportation, and other issues that can impact a person's overall health.

The IHH model uses care coordination teams, which include a registered nurse, a peer support specialist, and a care coordinator. For children, the team includes a family support peer specialist who has lived experience. Care coordinators are people who have a great deal of understanding about the resources in the community. Nurses have a medical and clinical background and the ability to connect with other medical personnel and review medical records. Peer Support Specialists have lived experience that helps them connect with and understand the needs of the individual. Each member of the care coordination team brings their own type of experience and expertise and they come together to use a team-based approach to support the individual.

- Phase 1 started on July 1, 2013 with five large population counties: Dubuque (children only), Linn, Polk, Warren, and Woodbury
- Phase 2 started on April 1, 2014 with 29 counties
- Phase 3 started on July 1, 2014 with the remaining 65 counties
- Each phase included a different amount of geographical coverage, but about one-third of the state's population
- The third and final phase of the IHH initiative was rolled out on July 1
- There are 40 IHH providers across the state; some work with multiple counties
- As of August 15, 16,054 members were enrolled
- It is estimated that about 50,000 people statewide meet the criteria due to mental health conditions

The idea is that the IHH adds the service of care coordination to the clinical service options people already have to help them find what they need, what they want, and assist them in making the connections. The care coordination team helps address any areas of concern and make sure that things are not overlooked.

Adults who have been receiving habilitation services and children who have been on the Children's Mental Health Waiver have had Targeted Case Management. As the IHH phases have been rolled out, those individuals have had six months to move their care coordination to the IHH. That allows them some time to build new relationships and do what is needed to transition as smoothly as possible.

Some providers serve adults only, children only, or both. Transition age youth have been allowed some flexibility in where they choose to enroll to be more member focused and get people into the service that is right for them (for example, a 17-year-old might choose to enroll with an adult provider).

As of July 21, 2014:

- 95% of adults in the Phase 1 counties have been transitioned from TCM (Targeted Case Management) to ICM (Integrated Care Model)
- 72% of adults in the Phase 2 counties have been transitioned from TCM to ICM



- 20% of adults in the Phase 3 counties have been transitioned from TCM to ICM
- 98% of children & youth in the Phase 1 counties have been transitioned to ICM
- 28% of children & youth in the Phase 2 counties have been transitioned to ICM
- 3% of children & youth in the Phase 3 counties have been transitioned to ICM

An IHH member experience survey was conducted. Hundreds of comments were received that helped inform IME and Magellan about things that are not working as well as they should or need some improvement. Overall, 90% of adult members reported satisfaction with their IHH provider services, and 87.9% of pediatric members or caregivers reported satisfaction with their IHH provider services. Early outcomes for people who had been in an IHH for six months include:

- 16% reduction of mental health emergency department visits
- 18% reduction in mental health inpatient admissions
- 16% reduction in medical inpatient days
- 12% reduction in medical emergency department visits

Performance and quality measures are in place. During the first year, baseline information is being gathered about members' physical and mental health status. Members are educated about preventative measures and maintaining good health, and are connected with resources. During the second year, providers will be working on ways to help members improve their health outcomes and quality of life. Some IHHs are starting walking clubs and offering nutrition and cooking classes. They are trying to be more wellness-oriented and preventive instead of just responding to health crises.

Kelley shared a map of the IHH providers by county and a chart of seven domain areas for pediatric IHH members as reported by parents and caregivers. The areas are medical, psychological, school, legal, economic, family, and residence. She said reporting from the first 9 months shows trends moving in the right direction.

Of the total number of 16,035 IHH enrollees to date, 5353 have been identified as eligible for Targeted Case Management, so the introduction of IHHs expands the availability of care coordination beyond those who are eligible for TCM to a much larger group.

Dave Klinkenborg added that every provider has a coaching entity. A group from Colorado has been contracted with to do site specific work and help providers transition to new practices. The University of Iowa has also used their experience with systems of care to work with pediatric IHH sites around practice transformation. Magellan also has been working with IME, MHDS, and child welfare, and to bring together work teams to problem solve.

Jill Davisson commented that the transition to IHHs in Jackson and Clinton counties are not going well. There seems to be a lack of training for providers that have never provided case management. Kelley responded that the program just started there in April and is still new to them. She said providers do receive training, but they also have to learn as they go and it takes some time to assemble teams of people and get them working well together. She said many areas have struggle in the early months because there is a tremendous learning curve.

Kathy Johnson commented that her area started in Phase 1 and it did take a while to get up to speed. She noted that community support is very important. Patrick Schmitz commented that he has only been able to hire one person who had experience as a case manager and that function is new to the organization, so people need to learn to take a while new approach. He said it is the largest initiative his mental health center has taken and, while he believes it is well worth it, it has been challenging.

Kelley said the change to IHHs bring a whole new way of doing things in a more patient-centered way that brings people together to problem solve and do what is needed to support the person. It is also a way to help redirect costs away from emergency room visits and inpatient hospitalization and toward preventative and lower levels of care.

Suzanne Watson asked about reimbursement rates. Kelley responded that IHH providers receive \$60 PMPM (per member, per month) based plus \$20 PMPM for meeting certain quarterly incentives for adults (\$80 PMPM) and \$103 PMPM for children. For children on the CMH (Children's Mental Health) Waiver there is an additional \$200 PMPM.

Kelley noted that there are a significant number of people who don't need daily or even weekly intervention, and a few who need a high level of support. The care coordination team determines what each person needs in terms of contact. She said teams are still working on becoming more efficient and that will happen over time.

Neil Broderick commented that over time he believes people with "high touch" needs stay in the system and some of the "low touch" people drop out, but a mix of both types is needed to make the economics of the system work. Dave Klinkenborg added that efforts need to be made to engage people with "low touch" needs so that they see the value of staying in the program. He also noted that people with "high touch" needs can be relatively stable with the right supports and once supports are in place will be less time consuming for the care team.

Tom Bouska asked if there are step down services available outside the child welfare system. Dave Klinkenborg responded that there are some community-based services that are missing it will take some time to adjust current services and add new ones. He said more flexibility and options may need to be created in the array of services.

Brett McLain commented that any veterans who are members of an IHH could be referred to their county Veteran's Services Officer. Each county has one who has been trained by the Veteran's Administration.

## PUBLIC COMMENT

No public comment was offered.

## COST RECOMMENDATION LETTER REVIEW

Patrick Schmitz read the cost increase recommendation letter with the revisions the Commission voted to make. There were no objections. The letter stands approved.

## COMMITTEE WORKGROUP REPORTS

MHI, SRC, and Disability Services Committee – Neil Broderick, Suzanne Watson, Brett McLain, and Marsha Edgington met. Suzanne reported for the group:

What is needed:

- Standardized collection of data that reflects outcomes and effectiveness statewide
- To identify what data could be used to measure effectiveness statewide
- A statewide reporting method that can measure if a person is stable where they live and happy with their living environment
- The number of discharges from State Resource Centers is available, but does not tell us how many people are asking to be readmitted, whether their community placement was successful, or if people are being moved from provider to provider due to problems with their service. Waiting lists only capture those that were accepted to be on the waiting list. We do not know how many people are in inappropriate places such as jails or hospitals because there are no other options available.
- Admission and discharge data is available for the MHIs, but there is not a way to track where people are discharged to, and if they have a good outcome from treatment.
- Efforts are underway to begin to collect outcomes through the MHDS regions, but the state is in the early stages of being able to pull together such data and it will take several years to get a data gathering system that can measure actual outcomes and effectiveness of providers.

Legislative Recommendations Committee – Jill Davisson, Tom Broeker, Betty King, and Geoff Lauer met. Jill reported for the group: The committee reviewed the Commission's legislative recommendations from last year and believe some of them should be carried forward.

They are also considering some new items:

- Addressing the Medicaid offset (claw back) and allowing counties to set their own levies rather than using equalization
- Requesting funding for transportation services, which are an issue with medical, mental health, and disability services and also in DECAT, early access, and the jail and juvenile systems
- Addressing the reduction of HCBS Waiver waiting lists and wait times

Regional Services Committee – Patrick Schmitz, Rebecca Peterson, Deb Schildroth, Kathy Johnson, Lynn Grobe, and Tom Bouska met. Kathy reported for the group, which suggested:

- Looking at FY2013 county data and how it matches up with services that value and want to continue
- Looking at regional plans for gaps and unmet needs

- Looking at incorporating Medicaid information since many services are funded by Medicaid

#### NEXT MEETING

The next Commission meeting is scheduled for September 18, 2014 at Polk County River Place.

The meeting was adjourned at 3:35 p.m.

Minutes respectfully submitted by Connie B. Fanselow.